FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Health Insurance Market Reforms: Guaranteed Issue

Overview

What is guaranteed issue?

Guaranteed issue laws require insurance companies to issue a health plan to any applicant - an individual or a group - regardless of the applicant's health status or other factors. Currently, in most states, insurance companies can deny nongroup coverage to people based on their health status or their medical expenses over the past year. This means that an uninsured person who develops a certain condition, such as breast cancer, might not be able to buy health insurance. In such an instance, insurance companies can (and often do) refuse to issue a health insurance policy to that individual. Guaranteed issue laws require insurance companies to issue a health plan to any applicant, including those with preexisting medical conditions. However, in some cases those companies may impose pre-existing condition exclusions on the policy, meaning that coverage for such conditions is not immediately available.

How is guaranteed issue regulated under current law?

In most states, insurers are not required to guarantee issue policies to individuals. However, under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, some insurance companies are required to guarantee issue policies to certain individuals, referred to as HIPAA-eligible individuals, regardless of their health status and disability. These individuals include people who have had at least 18 months of prior coverage, the last day of which was under a group health plan. They cannot have more than a 63-day gap in coverage, and they must have exhausted any COBRA or state continuation coverage for which they were eligible. Such individuals must be guaranteed some type of coverage. States can decide whether that coverage should be available from private insurers or available in some other way (such as through the state's high risk pool). Although federal law requires that coverage be available, it does not limit how much insurance companies can charge HIPAA-eligible individuals for coverage. Without a limitation by the states, this coverage can be very expensive.

In the small group market, HIPAA requires all health plans for small groups (employers with 2 to 50 employees) to be guaranteed issue. HIPAA does not require guaranteed issue for self-employed adults or for groups with more than 50 employees. However, some states have broader guaranteed issue requirements than the federal rules.

In addition, insurers can still deny coverage for a handful of other reasons, including:

- The applicant does not live in the insurer's service area;

- For a small employer, the group does not meet minimum participation rates (i.e., the proportion of employees purchasing coverage does not meet a defined threshold of participation) or contribution rules (i.e., the amount or level of contribution that an employer must make towards employees' premiums); or
- The applicant does not qualify for the coverage (for example, an employer with 25 workers wants to buy a health plan only marketed to groups with over 50 workers).

How does the Affordable Care Act (ACA) affect guaranteed issue?

The ACA requires significant changes to guaranteed issue laws. Beginning January 1, 2014, all individual and group health plans must guarantee issue policies to all applicants, regardless of health status or other factors. For children under the age of 19, beginning September 23, 2010, issuers were prohibited from imposing preexisting condition exclusionary riders (i.e., an insurance company cannot refuse to pay for chemotherapy for a child with cancer because the child had the cancer before obtaining insurance) and outright coverage denials (i.e., an insurance company cannot refuse to issue a policy to the child because of the child's cancer). The ACA's guaranteed issue provision applies to all group plans and new plans on the individual market, but does not apply to grandfathered individual plans. Grandfathered plans are those that were in existence as of the date the ACA was enacted (March 23, 2010). These plans, which could be sold to individuals or groups, are exempt from most, but not all, of the ACA's insurance market reforms.

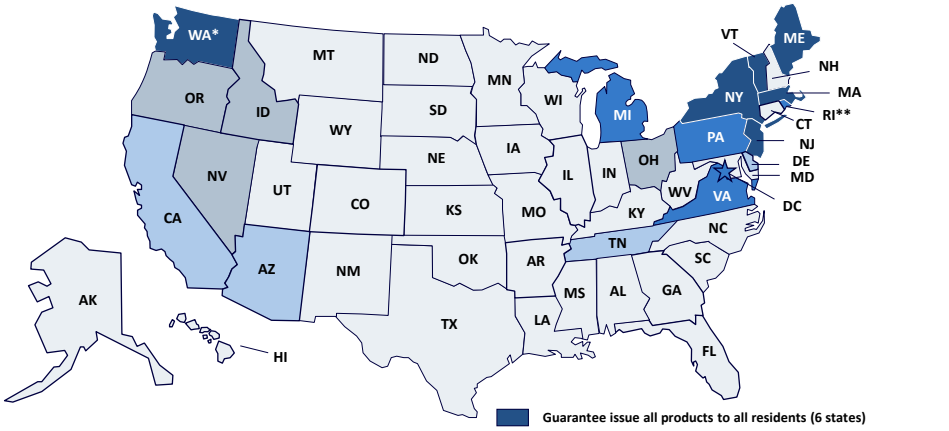
Current Status and Trends

Individual Market

In most states, insurance companies are permitted to deny nongroup coverage based on health status or other risk factors. Some insurers maintain lists of up to 400 different health conditions that could trigger denial of an application. With respect to the individual market, state guaranteed issue laws vary. For example:

Figure 1

Guaranteed Issue Laws in the Individual Market, June 2012



NOTE: *Washington guarantees all products to individuals who achieve a minimum score on the state's health status questionnaire.
**Rhode Island also requires all individual market carriers to guarantee issue to HIPAA-eligibles.

Source: Data available at www.statehealthfacts.org; compiled by the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

- In five states (Maine, Massachusetts, New Jersey, New York, and Vermont), individual market insurers are required to guarantee issue all products to all residents. A sixth state, Washington, requires guaranteed issue to individuals who achieve a minimum score on the state's health status questionnaire.
- In five other states (DC, Michigan, Pennsylvania, Rhode Island and Virginia), a Blue Cross Blue Shield carrier has been designated as the issuer of last resort, meaning it will issue coverage to all who apply, regardless of their health status.
- Five states (Arizona, California, Delaware, Rhode Island and Tennessee), require all individual market carriers to guarantee issue coverage to HIPAA-eligible individuals, but to no other residents.
- Four states (Idaho, Nevada, Ohio and Oregon) require insurers to guarantee issue coverage to HIPAA-eligible individuals as well as to certain other residents with prior continuous coverage.
- Many states that don't require guaranteed issue plans in the individual market have high-risk pools that will cover people turned down by private insurers. Also, under the ACA, all states have a Pre-existing Condition Insurance Plan (PCIP) for individuals who have been denied coverage and been without health insurance for at least six months.

Small Group Market

Under federal law, insurance companies are required to guarantee issue coverage to small groups. In 14 states, self-employed individuals are also eligible to purchase guaranteed issue coverage in the small group market.

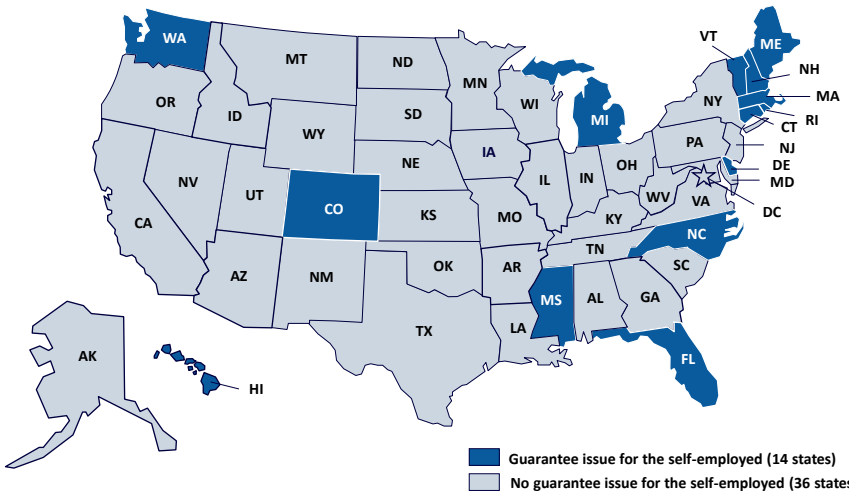
Transition to 2014

Individual Market

The ACA's guaranteed issue requirements will result in greater changes for the individual market than for the small group market. Currently, there are only six states that require insurance companies to guarantee all products to all residents. Beginning January 1, 2014, insurance companies are required to guarantee issue all policies to all residents. In most states, this will require legislative or regulatory changes by 2013. In addition, high-risk pools may become

Figure 2

Guaranteed Issue Laws in the Small Group Market, June 2012



Source: Data available at www.statehealthfacts.org; compiled by the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

obsolete as states pass laws requiring insurers to cover these individuals in the private market.

Small Group Market

The ACA reaffirms the 1996 HIPAA law, requiring insurance companies to guarantee issue and renew coverage to small groups. As a result, states are unlikely to need significant legislative or regulatory changes in order to conform to the federal standard.

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